

Assessment Report 2003

Health Improvement Program



Summary Report



HMG/MoH/DoHS
 Eastern Regional Health Directorate
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The Britain Nepal
 Medical Trust

Assessment Report 2003

Health Improvement Program

A SUMMARY REPORT ON ASSESSMENT OF HEALTH SITUATION IN EASTERN DEVELOPMENT REGION OF NEPAL

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FOREWORD

The Britain Nepal Medical Trust aims to assist in health improvement in Nepal. Its work began in 1967 when a group of doctors from the UK received permission from the Nepal Government to work voluntarily in the Eastern Region of Nepal. It has developed to meet the changing demands it has encountered over the past 35 years. BNMT in the past tried to ensure that its services and programs were accessible to all members of the community. However, in an unequal society, many community members are still unable to access services due to reasons of caste, extreme poverty and gender inequalities. It is committed to exploring new and more effective ways in which it can increase access to the poorest and most marginalized community members.

HMG has developed the Second Long Term Health Plan (SLTHP) for 1997-2017 based on the National Health Policy of 1991. The SLTHP focuses on equitable access to quality health services for all with special emphasis on the most vulnerable groups, particularly women children and the *poor and marginalized* populations. However, the health system is failing to meet the needs of disadvantaged groups particularly women, children, *Dalits*, rural poor, and disadvantaged and socially marginalized groups.

This situation calls for various stakeholders including governmental, nongovernmental, private, local government and donor organizations to work in a partnership and participation approach to improving the access of disadvantaged groups by creating the demand for and the supply of quality health services.

BNMT with its key partners and community has adopted an approach called 'Partnerships and Participation (P&P)' to mobilize the local communities for developing a reliable and equitable system. It is working towards greater integration through the development and implementation of an integrated Health Improvement Programme (HIP) with four major health components:

Infectious Diseases (IDs), Reproductive Health-Safe Motherhood (RH-SM), Tuberculosis (TB)/ Human Immuno-deficiency Virus (HIV) / (Acquired Immuno-Deficiency Syndrome (AIDS) & Sexually Transmitted Infections (STIs) and Essential Drugs (EDs).

In 2003 BNMT and its key partners actively participated to carry out a detailed assessment of health utilization and health services provisions in more than 8,061 households in 203 villages in all 16 districts of the Eastern Development Region of Nepal. The HIP has formed different committees/teams at central, regional, district and community levels to carry out the situation analysis.

The main objective of the assessment was to identify the current situation and the gap between service delivery and utilization of health with a special focus on four health components. It was assumed that the assessment could support the analysis of the current/general situations of the health care system in the eastern region, to establish baseline information as a basis for developing a plan, implementation of activities, monitoring and evaluation. It provides information to design suitable interventions/methods for the capacity strengthening of partners and the community.

It also provides insight into the current socioeconomic, and demographic situation that affects the health of the community people. The data can be used to identify the gaps in the provision of quality services at different levels of health care, and to identify community practices in utilizing the health care services in particular to access to services, barriers to utilising existing services, barriers to change behaviours and, identification of specific health concerns /needs of community people.

The study was descriptive and analytic. Both quantitative and qualitative information was collected using questionnaires, in-depth interviews, focus group discussions and documentary analysis.

HMG, development partners, local bodies and all the BNMT staff members were fully involved in the assessment process, together with the external consultants, partners, communities and key stakeholders. A series of community meetings were held before the data collection. The data collection has been completed in all districts of the Eastern Development Region. The data has been primarily processed by AC Nielsen (a consultancy firm). The results of the survey are being discussed and interpreted with the key partners

and communities according to the following process before planning the detailed activities:

- Health services available for the disadvantaged groups Status of health facilities in the Government sector
- Health services available for the disadvantaged groups
- NGOs/Private sectors working in service provision and their status
- Utilization of available services, types and quality of services available, awareness of the availability of health facilities
- Utilization of health services by the disadvantaged group
- Barriers to access o Support needed for disadvantaged groups o Major issues/problems being shared with partners for detailed planning.

I would like to thank Dr Mahananda Mishra, Director of Eastern Regional Health Directorate (ERHD) Mr Yogendra Mandal, Act. Chief, RHTC, Dhankuta, Mr Nawaraj Subba, Public Health Administrator (ERHD), Mr. Ram Dhan Mehta, PHA, Mr Pan Bahadur Chhetri, Chief of ERMS, Ms Bhagawati Chaudhari, President FORWARD, Ms Manorama Adhikari, Research Executive (AC Nielsen Pvt. Ltd), Nischal Basnet, Project coordinator (ACNielsen Pvt. Ltd), Deepak Paudel, Freelance consultant and BNMT Staff and SMT members for their valuable input in the entire process of the assessment. Thanks are also due to Mr Lila Acharya, Sr. Field Executive, Mr. Ramesh Pradhan, Senior Analysis Executive, Ms. Sabina Pradhan, Research Officer of AC Nielsen Pvt. Ltd for their valuable support in data compilation and analysis.

Chanda Rai
Chief Executive, BNMT

PREFACE

The study to assess the health and healthcare delivery status in the Eastern Development Region of Nepal was carried out by the Health Improvement Program of The Britain Nepal Medical Trust (BNMT) in close collaboration and coordination with the Eastern Regional Health Directorate. This study is expected to provide insights into the current status of health; gaps in availability, accessibility and utilization of health care services; current and potential aspects that affect health and thus to guide health managers and partners to identify appropriate interventions to improve health status in the Eastern Development Region of Nepal through strengthening the capacity of local communities.

This assessment was funded by BNMT and facilitated jointly by BNMT and Eastern Regional Health Directorate. Information was collected from households, health facilities, private clinics, nursing homes, private drug retailers and traditional faith healers from all 16 districts of the region. This is probably the first assessment of this kind covering a wide range of information collection approaches in all districts of the region. AC Nielsen Nepal Private Limited provided technical support for tools development, training of supervisors and enumerators, data entry and preliminary analysis of the data.

This report includes the key findings of the assessment. It is a summary for dissemination to the central-level partners. At this moment, we would like to thank all members of central, regional, district and community-level assessment teams for their contribution to the entire process of assessment. We would also like to thank officials from AC Nielsen Private Limited, Eastern Regional Health Directorate and Britain Nepal Medical Trust for their immense and continued support and encouragement.

Finally, we hope this report together with the main report will be fruitful to develop, review, revise and monitor the programs aiming to improve the health status in the Eastern Development Region of Nepal. The results will guide the development of a strategic way, for both government and nongovernmental sectors, to fulfil immediate needs and to establish basic

rights to the health of the people living in the eastern region through sustained health care delivery and empowered community systems.

Shiba B. Karkee
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BACKGROUND AND METHODOLOGY

The study on the Assessment of Health Status in the Eastern Development Region (EDR) of Nepal was conducted with the joint effort of The Eastern Regional Health Directorate and Britain Nepal Medical Trust. The objective of the survey was to support the Health Improvement Programme of ERHD/BNMT.

It provides insights to develop innovative approaches to build the capacity of communities and partners to improve the 'demand for', 'access to' and 'supply of' quality health services in remote and most needy people of the Eastern Development Region of Nepal.

At first, a regional-level assessment team was established to design the method and tools used in the study. Then, district-level assessment teams were formed for the overall operation of the fieldwork. A committee was also formed in each VDC for facilitating and monitoring the assessment activities. The study constitutes both quantitative and qualitative tools. The Quantitative tools were used to collect information from households, NGOs/CBOs, health care facilities, private clinics/nursing homes, drug retailers and exiting patients from health facilities. Qualitative tools were used to collect information from traditional healers, the health facility in charge, community people, local health committee members and FCHVs.

The assessment study was conducted in all 16 districts of the Eastern Region of Nepal. Overall 203 VDCs of the Eastern Region were covered for the household survey whereas, in terms of assessing the health institutions, the research team visited more than 203 VDCs. Overall, the household study enumerated 8061 households (4,026 disadvantaged and 4,035 general) using structured questionnaires. The disadvantaged and advantaged groups of households were listed through a participatory manner using social mapping (the local village-level assessment committee categorised the total households of the village into general and disadvantaged segments). Then, 20 households from the general list and 20 households from the disadvantaged list were randomly selected for the data collection.

Likewise, in-depth interviews with 48 traditional healers, 93 HI In-Charges, 32 FGDs with community people, 16 FGDs each with health committee members and FCHVs/TBAs were conducted.

- Interview with 1,311 exiting patients was also conducted using structured questionnaires. Twenty exit patients from each hospital and 5 exit patients from each health facility were selected. Data were also collected from 59 nursing homes/ private clinics, 83 drug retailers, 84 NGOs and 75 CBOs using structured questionnaires.

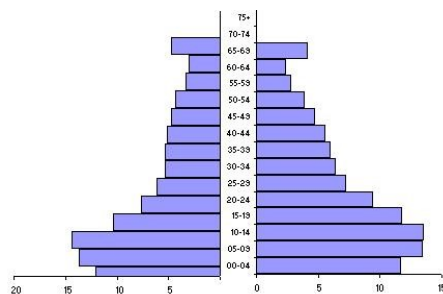
FINDINGS

Demography

Overall a large proportion of EDR's population (50%) is under 19 years of age; the proportion of the same is marginally higher in the disadvantaged segment (54%). The proportion of children under five years of age is higher among the disadvantaged segment as compared to the general segment which suggests a lower fertility rate among the general as compared to the disadvantaged group.

On an overall sex ratio, the number of males per 100 females is 97.9. About 28% of the households belonged to *Dalits*. The proportion of *Dalits* was higher in the disadvantaged segment (47%) as compared to the general segment (9%).

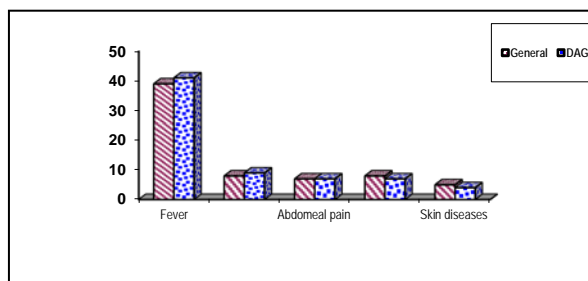
About 45% of the respondents were illiterate and the proportion of illiterates was higher in the disadvantaged segment (61%) as compared to the general segment (29%).



Morbidity

About 5.7% of the surveyed population (household members) had fallen sick within the last 15 days of the interview; the incidence was marginally higher in the disadvantaged segment.

Among those who were sick, most of them were suffering from fever (40%) followed by diarrhoea (8.5%), gastritis/abdominal pain (7.4%), ARI (7.3%) and skin diseases (4.1%).



When inquired about their health-seeking behaviour 23.5% reported visiting a health institution, 35.4% visiting private clinics/doctors/drug retailers and 16% traditional healers. Besides, only about 19% of the disadvantaged females "I cannot say the exact visited health institutions for treatment number of how much I compared to 26% of females from the

general treated in a year. But I am segmented. Family members (45%) seem to be sure that I have cured the main source of advice to visit health more than 150 patients facilities. this year and some 30-35

Out of the total cases (household members) suffering from pneumonia, diarrhoea, dysentery and typhoid and who visited health facilities for treatment, 35% had prescriptions. Among them, about 70% were prescribed at least one antibiotic. However, only 48% of such patients completed the full course of antibiotic therapy and 39% were continuing with the course.

"I cannot say exact number of how much I treated in a year. But I am sure that I have cured more than 150 patients this year and some 30-35 patients were referred to doctors or health institutions. Diseases here found are cough, asthma, Undernutrition, fever, headache, diarrhoea, paralysis etc"

- Traditional Healer

Tuberculosis

About 89% of respondents from the general segment and 73% from the disadvantaged segment had heard about Tuberculosis. Of them, about 47% from the general segment and 43% from the disadvantaged segment correctly stated signs/symptoms of Tuberculosis (cough for more than two weeks, blood in cough, fever, weight loss and chest pain).

About 85% of the respondents (90% general and 80% disadvantaged) reported that they would contact health institutions if suffered from a cough for more than two weeks. The respondents from general households were more likely to contact health institutions as compared to those from disadvantaged households. Besides, about one-third of the respondents reported that they would follow home therapy.

Though the drugs for the treatment of TB are freely available at health institutions, only 46% of respondents (59% general and 33% disadvantaged) were aware of free drugs available for the treatment of TB.

About 66% of the respondents (76% general and 56% disadvantaged) correctly reported the mode of TB transmission. Only about 3.5% of respondents (6% general and 1% disadvantaged) had heard about DOTS.

Family Planning

About 87% of respondents were aware of family planning; however, the level of awareness was lower among disadvantaged households (81%) and disadvantaged females (80%). About 85% of respondents could mention two or more types of family planning methods. Depo- Provera was the commonly reported (83%) method of family planning followed by oral pills (71%) and condoms (64%). The majority of respondents were aware of the place for the

availability of temporary family planning methods. Among the total married couples living together, about 8% were using condoms, 9% using pills and 36% were using depo injections.

HIV/AIDS/STI

About 61% of the respondents had heard of HIV/AIDS and which was lower among the disadvantaged segment (46% as compared to 75%). More females from general households had heard of HIV/AIDS as compared to females of disadvantaged households (70% as compared to 41%).

The main source of information on HIV/AIDS was electronic media like TV/radio (87%), followed by family members/neighbours/relatives (54%), and health workers (23%).

About 45% of the respondents could report at least two ways of HIV/AIDS prevention. The knowledge of HIV/AIDS prevention was higher among the general than in the disadvantaged segment (60% as compared to 31%).

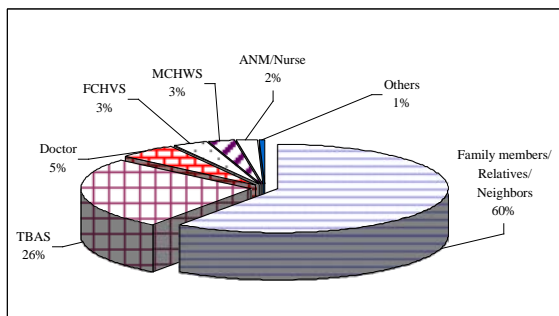
Nearly half (46%) of the respondents (59% general and 33% disadvantaged) had heard about STIs. Most of them reported visiting health institutions (71%), followed by private clinics/drug retailers (27%) for the treatment of STIs. About 21% of respondents expressed that using condoms while having sex prevents STIs.

Safe Motherhood

About 66% of the respondents were aware of the danger signs of pregnancy. Of them, about 48% mentioned vaginal bleeding as a dangerous sign during pregnancy. The other danger signs reported were lower abdominal pain (47%), headache (40%), swelling of limbs (38%), weakness (24%), unconsciousness (11%) and high fever (4%). Besides, 63% of the respondents were aware of the danger signs during pregnancy. The majority of them (68%) expressed vaginal bleeding as a danger sign during a delivery. The other danger signs reported were prolonged labour (49%) followed by mal-presentation (27%), swelling of limbs (26%), headache (25%), weakness (23%), unconsciousness (21%) and lower abdominal pain (7%). Of the total respondents, vaginal bleeding (42%) followed by swelling of limbs (20%), headache (20%), weakness (20%), (7%), high fever (15%), unconsciousness (14%), vomiting (9%) were the reported danger signs after delivery.

Of the total respondents, about 30% reported that pregnant women should visit 2-3 times for health check-ups during pregnancy. About 23% of the respondents reported that pregnant women should visit 4-5 times for health check-ups during pregnancy.

It was found that, among the deliveries in the last three years, about 87% were carried out at home and 11% were carried out at hospitals. In comparison to the general households, significantly a less number of disadvantaged households used the hospital for delivery.



Of the deliveries carried at home, most of the cases were assisted by family members/relatives/neighbours (65%).

A clean home delivery kit was used in 30% of the deliveries carried out at home. It was found that general households were more likely to use clean home delivery kits than disadvantaged households. Out of the deliveries carried out at home without using the clean home delivery kit, only about 1.3% used clean blades and the remaining reported the use of iron-made cutting instruments and bamboo sticks.

Infectious Diseases

Diarrhoea

The majority of the respondents (69%) reported diarrhoea as more than 3 loose motions in 24 hours. Dry mouth (46%), thirst (38%) and sunken eyes (33%) were commonly reported symptoms of dehydration.

About 60% of the respondent (67% general and 53% disadvantaged) reported that a child suffering from diarrhoea should be treated with ORS.

"I treat fever, diarrhoea, menstrual bleeding and they get well. I treat them with *Jadibuti* (herbs) for 10 days. Patients those do not get well in that 10 days be referred to the doctor or health institutions."

- *Traditional Healer*

ORS was found in only 8% of the total households (general 10% and disadvantaged 5%). Of 1161 respondents of Morang and Udayapur, about 73% reported that they could prepare ORS. But when asked to prepare it, only 77% of them could prepare the solution correctly.

Pneumonia

About 84% of respondents had heard about Pneumonia. Most of them reported fever and cough (62%) as the symptoms of pneumonia followed by wheezing (58%), fast breathing (30%) and chest indrawing (24%). The majority (87%) of the respondents reported that they would take a child suffering from pneumonia to a health institution/worker, and about 34% stated that they would consult private clinics/drug retailers. However, quite a several respondents (14%) said they would consult a traditional healer for the same (general 9% and disadvantaged 19%).

Malaria

Of the total respondents, 69% had heard of Malaria. Among those who heard of Malaria, fever with chills (70%) and high fever (69%) were the reported symptoms of malaria. Of all the respondents, about 43% reported that malaria is transmitted through the bite of a mosquito (general 55% and disadvantaged 30%). The use of mosquito nets (62%) and use of mosquito coils (22%) were reported as the method of prevention of malaria followed by maintaining sanitation (16%) and the use of insecticides (19%). General household members were more likely to use mosquito nets compared to disadvantaged households (58% as compared to 34%).

Kala-Azar

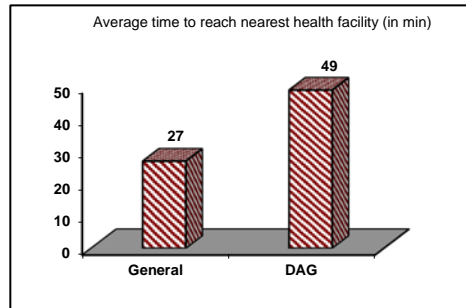
More than half of the respondents (53%) had not heard of Kala-azar, and only about 14% of the respondents mentioned that the disease is transmitted through the bite of a sandfly. Of the respondents who had heard of Kala-azar, high fever (59%), fever with chills (43%), sweating (9.6%) and stomachache (3%) were the reported symptoms. Regarding the source of getting drugs for Kala-azar, health institutions were the frequently described source (72%) followed by drug retailers/private clinics (31%) and traditional healers (0.7%).

Japanese Encephalitis

Only about 21% of the respondents had heard about Japanese Encephalitis. High fever (49%), no movement of limbs (48%), headache (40%) and vomiting (13%) were the most repeated responses regarding symptoms of Encephalitis. About 16% of all respondents stated that the disease is transmitted through the bite of a mosquito. Regarding the source of getting drugs for Encephalitis, health institutions (58%) were the frequently described source followed by drug retailers (24%).

Access to Health Services

The average time to reach the nearest health facility by walking was about 38 minutes (27 minutes in the general segment and 49 minutes in the disadvantaged segment). About 12% of households (5% general and 18% disadvantaged) reported that they have to walk more than 60 minutes to reach the nearest health facility.



Satisfaction towards Health Services

About half of the respondents reported being partially satisfied and 16% reported being fully satisfied with the services of traditional healers. The main reasons for satisfaction were the efficiency of traditional healers to cure some diseases that could not be treated by modern medicine. The respondents reported headache (38%), fever (30%), stomachache (27%) and dizzy spells (12%) were the common health problems for visiting the traditional healers.

"I have cured many people. Most of them revisit me after getting well. It makes me happy and satisfied."

"People appreciate my job, that's why I am satisfied."

- Traditional Healer

About 42 % of households (60% general and 24% disadvantaged) possessed toilets in their households. Of them, only about 31% had water facilities.

About 47% of households stated that they used a pit to dispose of waste materials. About 24% stated that they burn the wastages.

Representation in NGO/CBO

The participation of female and *Dalit* members in the executive body of local NGOs was found poor (about 3.3 females and 0.7 *Dalits* per NGO), though the majority (94%) of NGOs reported that they were working for community empowerment. Similarly, the participation of females and *Dalits* in the executive body of CBO was only 7.6 and 3.1 respectively.

District Hospital

Of the total 670 sanctioned posts in district hospitals, only 83% were filled. Of the total filled positions, 90% were present on the day of the visit. On the day of the visit Medical Superintendent was found present in 50% of hospitals, and Medical Officer was found present in about 81% of hospitals.

Out of the total 16 hospitals, 10 had displayed IEC materials on essential drugs, 16 on reproductive health, 14 on infectious diseases, 14 on HIV/AIDS/STIs and 11 on Tuberculosis. Fourteen district hospitals were working as DOTS centres. All district hospitals had lab services (including a sputum microscopy facility), 15 had malaria testing and pregnancy testing facilities and only 9 had ELISA testing facilities.

Six district hospitals had implemented drug schemes. On average, about 86% of key drugs (range 77 to 97%) were available in those hospitals. In the remaining 10 hospitals, on average, the key drug availability was about 71% (range 41 to 97%). Of the 6 hospitals with drug scheme, on average the balance of the revolving drug fund was about Rs. 315,000.00

All district hospitals were equipped with labour rooms and functional toilets and fourteen hospitals had a separate room for ANC/PNC.

Although 79% of pregnant women were found anaemic, about 55% of them received iron and folic acid tablets.

Public Health Office/Section

Of the total 356 sanctioned posts for the Public Health Offices/Sections of EDR, about 86% were filled. Of the filled posts, about 66% of the employees were present on the day of the visit.

Medicines were found organised according to the FEFO system in the stores of 14 public health offices/sections.

An annual plan of action was found prepared in 13 public health offices/sections, and an annual plan for supervision/monitoring was found prepared in 12 public health offices/sections.

Health Facility Situation

A total of 185 health facilities (26 PHCs, 80 HPs and 79 SHPs) were visited for a health facility survey. Out of the total sanctioned posts, only 72% were filled in PHCs, 84% in HPs and 90% in SHPs. Of the total sanctioned posts of key health workers for providing maternal and child health services, about 35% (9/26) of staff were present on the day of visit in PHCs, 48% (38/80) in HPs and 64% (50/79) in SHPs.

"We don't have special programs for disadvantaged but we give them priority in the program so far as possible. We are interested to implement Disadvantaged Group (DAG) oriented programs."

- Health Worker

Out of 26, PHCs visited, 17 (65%) had all the key drugs recommended by WHO¹, whereas key drug availability in HPs and SHPs was 59% (47/80) and 55% (43/79) respectively.

The drug storage system was found poor in most of the health facilities. The average value of expired/damaged drugs was Rs. 5,876 in PHC, Rs 3,428 in HPs and Rs 3,344 in SHPs.

Private Clinic/ Nursing Homes

Of the total 59 private clinics/nursing homes, 69% had OPD services, 10% had in-patient services and 56% had emergency services. Emergency service was available in at least one Nursing Home/Private Clinic of all surveyed districts except Udaypur.

The private clinics/nursing homes were found providing services on safe motherhood (68%), and treatment for malaria (27%), Kala-azar (12%), Tuberculosis (10%) and Japanese Encephalitis (7%). About 95% of the private clinics/nursing homes reported referring patients to government hospitals for further treatment and care.

Drug Retailers

A majority (85% of the total 83) drug retailers had completed their SLC (10 years of schooling); 46% had received technical training (e.g. HA, CMA, ANM etc) and 45% had received orientation training for drug retailers.

Majorities of the drug retailers had key drugs to treat common health problems (94% had Amoxycillin, 79% had Cotrimoxazole, 51% had

Iron/Folic Acid Tablets, 57% had Mebendazole, 90% had ORS and 80% had Doxycycline.

Only 41% of the retailers could report at least four characteristics of rational use of drugs¹.

For a child below 3 years suffering from acute diarrhoea, about 26% of retailers recommended ORS only.

Exit Poll

Of the total 1311 patients interviewed in the exit poll, about 30% were from hospitals, 9% from PHCs, 29% from HPs and 32% from SHPs. Of them, 48% were males and 52% were females. Of the total patients, 42% were less than 15 years, 55% were between 15 to 65 years and about 3% were above the age of 65 years.

The top-ten health problems diagnosed were fever (12.9%) followed by cough (8.2%), abdominal pain (6.2%), wound/abscess (6.1%), headache (5.3%), diarrhoeal diseases (4.2%), ARI (4.1%), worm infestations (3.6%), peptic ulcer syndrome (3.4%), and otitis media (3.2%).

On average, 2.14 drugs (range: 1.7 to 2.8) were found prescribed for each patient. Of the total prescribed drugs, about 68% were dispensed from the health facilities but about 20% of patients did not receive any drug. About 58% of prescriptions included at least one antibiotic drug. About 7.5 % of dispensed drugs were completely labelled. About 56% of the existing patients had correct knowledge of the dosage (dose, frequency of dosing and duration) of all drugs received at the health institution.

84% of the patient reported that health workers provided sufficient consultation time for their check-ups and 68% of the patients were satisfied with the advice given by health workers. Similarly, 49 % of the patients were asked for a follow-up.

Ensuring efficient and trained health workers available at health facilities (48%), ensuring availability of essential medicines and equipment (47%) and better infrastructure of health facilities (5%) were the key suggestions provided by the patients for service improvement.

¹ Right patient, right drug, right dose, right duration, affordable cost and right prescriber

KEY FINDINGS FROM THE QUALITATIVE SURVEY

Perceptions towards local health institutions

People felt the most urgent need was for trained manpower, medicines and equipment to be available in health institutions. Health workers are not accessible, especially to disadvantaged groups.

People expressed dissatisfaction with health institutions and health workers, saying that often health workers were not available when they visited.

Perceptions of health workers towards service delivery and utilization

Service providers noted the increase in people going to health institutions for treatment, and gave credit for this to the female community health volunteers, traditional birth attendants and community health education.

Service providers agreed that short opening hours and the capacity and behaviour of health workers were also reasons why people did not visit health institutions.

Cost of treatment from Traditional healers

"I don't take any kind of fee for my treatment. After getting well people come back and give me some clothes, money, fruits, meat, and Kalash with a flower to satisfy my deity. I take some money (Rs.51) for a *Buti* (herbs/thread) if someone needed it to wear."

"I don't say anything for my fee. I take 5-10 rupees if people offered me"

"I do not take money but some people do repay my service fees by their labour work in the field (Khetala)."

"I don't have asked for my treatment fees. But people have given me a maximum of Rs. 150.00 in cash and one *Pathi* rice in goods."

Barriers to accessing health services

Women hesitate to visit health institutions because of a lack of female health workers. Other reasons given for not going to health institutions included racial discrimination and an inadequate supply of medicines.

Household leaders do not like to send their sick members to the hospital; they prefer to consult a traditional healer.

People do not prefer to visit health institutions due to the regular unavailability of medicine and even if they visit, they have to get medicine from drug retailers.

Most of the women don't know what the official time of the local health post is.

SUGGESTIONS FOR IMPROVING ACCESS

- There should be a provision for female health workers to examine female cases.
- Health awareness training should be provided to traditional healers.
- Women should be called to meetings held in the local health centre.
- Skill development training for female volunteers and midwives.
- The general public should participate in meetings.
- If the patient is in serious health personnel should go home for treatment.
- Required medicine should be availed.
- Every activity should be transparent.
- Availability of 24-hour medical facility.
- Free medical facilities for poor people.
- Additional programmes for disadvantaged people.

CONCLUSIONS AND RECOMMENDATIONS

The study was carried out in 16 districts of the Eastern Development Region to assess the present levels of health status to guide in developing a detailed plan for the Health Improvement Programme.

Information was collected from different sources (8061 households, 185 Health facilities, 159 NGOs/CBOs, 83 drug retailers and 59 private clinics/nursing homes, 32 FGDs with community groups and 16 FGDs with local health facility management committee) and analyzed between male-female and disadvantaged-general population segments.

The majority of respondents were found illiterate and significantly higher among the disadvantaged segment. Major illnesses affecting the population were fever, diarrhoea, gastritis/abdominal pain, ARI and skin diseases. Though health facilities were reported as the main place of contact for seeking health services, a significant proportion of the population was still visiting traditional healers.

Prescribing antibiotics for illnesses like pneumonia, diarrhoea, dysentery and typhoid) was significantly higher but only a part of them was completing the full course of medication. Though majorities of the population had heard about common diseases (*like Tuberculosis, HIV/AIDS, Diarrhoea, Pneumonia, Malaria, Kala-azar and Japanese Encephalitis*); only a few of them could report correct signs/symptoms and measures for prevention.

A wide gap was observed between the knowledge and practice of family planning methods among married couples living together. The use of depoProvera was a common method of spacing. Knowledge regarding danger signs during pregnancy, during delivery and after delivery; regular antenatal checkups; delivery by trained persons; use of clean delivery kit needs improvements. Audio-visual mass media and local health workers and volunteers are potential media for imparting knowledge and motivating community members to improve their practices.

Very few female and *Dalit* members were found involved in local nongovernmental organizations and community-based organizations.

The study suggests that knowledge, practice and coverage of health were poor in the communities of EDR and a significant disparity was observed between disadvantaged and general segments of the population. Thus, appropriate interventions, especially targeting disadvantaged populations, are essential to improve the knowledge and practice on health issues and to maximize the utilization of health services.

The study results also demonstrate some good practices in healthcare delivery systems. However, there is still enough room for improvement in strengthening the drug management system, and filling up staff for providing MCH services and supervision based on the plan. Private Clinics/Nursing Homes/Drug retailers were found potential sectors to fill the gap in health service delivery from the public health system.

The study also suggests appropriate interventions for improving consultation, prescribing and dispensing practices at health facilities.

Programmes need to be focussed on the disadvantaged since the assessment has revealed remarkable gaps in terms of access and utilization of healthcare services between the disadvantaged and the general population.

Fact Sheet

Indicator	General	DAG	Odds Ratio (95%CI)
Household Survey			
Sex Ratio (male per 100 female)	96	99	
Population depending on agricultural occupation (%)	44	37	
Literacy (%)	71	38	3.84 (3.50 – 4.21)
Morbidity rate (last two weeks)	5.4	6.0	0.88 (0.81 – 0.95)
Treatment from traditional healers	11.3	20	0.51 (0.14 – 0.63)
Completed full dose of antibiotic therapy (%)	50	46	1.15 (0.43 – 3.1)
Knowledge of availability of free drugs for tuberculosis treatment (%)	59	33	2.90 (3.17 – 2.65)
Knowledge of at least two methods of family planning (%)	91	79	2.62 (2.28 – 3.01)
Contraceptive Prevalence Rate (%)	44	33	1.63 (1.46 – 1.81)
Knowledge of at least two ways of HIV AIDS prevention (%)	69	38	Check
Deliveries conducted at home (three years history recall) (%)	80	93	3.97 (3.05 – 5.16)
Using clean delivery kit in-home delivery (%)	39	24	2.07 (1.75 – 2.45)
Knowledge of using ORS for diarrhoea management (%)	66	53	1.76 (1.61 – 1.93)
Households with ORS packets available (%)	10	5	0.12 (0.10 – 0.13)
Households using mosquito nets (%)	34	58	2.66 (2.43 – 2.91)
Average time to reach nearest health facility (in minutes)	27	49	- -

Satisfaction with the services of health facilities (%)	77	70	1.45 (1.32 – 1.61)
Households with toilet facility (%)	60	24	4.84 (4.40 – 5.33)
Households with access to piped water supply (%)	55	46	1.42 (1.30 – 1.55)
Exit Poll	Value		
The average number of drugs prescribed	2.14		
Encounters with at least one antibiotic prescribed (%)	58		
Patients with correct knowledge of dosage (%)	71		
Dispensed drugs with complete labelling (%)	5.9		
Health Facility Survey	PHC	HP	SHP
Staff present on the day of visit (% of filled positions)	72	84	90
Key drugs availability (%)	65	59	55

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